DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PARTS C AND D OVERSIGHT AND ENFORCEMENT GROUP

March 22, 2022

Ms. Amber Cambron
President & Chief Executive Officer, BlueCare Tennessee
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402

Mr. JD Hickey
President & Chief Executive Officer
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug
Contract Numbers: H3259 and H7917

Dear Ms. Cambron and Mr. Hickey:

Pursuant to 42 C.F.R. §§ 422.752(c)(1), 422.760(b), 423.752(c)(1), and 423.760(b), the Centers for Medicare & Medicaid Services (CMS) is providing notice to BlueCross BlueShield of Tennessee (BCBS of TN) that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **$142,676** for Medicare Advantage-Prescription Drug (MA-PD) Contract Numbers H3259 and H7917.

An MA-PD organization's primary responsibility is to provide Medicare enrollees with medical services and prescription drug benefits in accordance with Medicare requirements. CMS has determined that BCBS of TN failed to meet that responsibility

Summary of Noncompliance

CMS conducted an audit of BCBS of TN's Medicare operations from May 3, 2021 through May 21, 2021. In a program audit report issued on August 27, 2021, CMS auditors reported that BCBS of TN failed to comply with Medicare requirements related to Part C organization determinations, appeals, and grievances in violation of 42 C.F.R. Part 422, Subparts C, M, and V. Two (2) failures were systemic and adversely affected, or had the substantial likelihood of adversely affecting, enrollees. The enrollees experienced, or likely experienced, delayed or denied access to covered benefits, increased out-of-pocket costs, and/or untimely appeal rights.

CMS reviews audit findings individually to determine if an enforceable violation has occurred warranting a CMP. CMPs are calculated and imposed when a finding of non-compliance adversely affected or had a substantial likelihood of adversely affecting enrollees. The determination to impose a CMP on a specific finding does not correlate with the MA-PD's overall audit performance.

Part C Organization Determination, Appeal, and Grievance Requirements
(42 C.F.R. Part 422, Subparts C, M and V)

A Part C organization determination is when an enrollee, provider, or legal representative of a deceased enrollee requests coverage or payment for an item or service with an MA organization. There are different decision-making timeframes for the review of organization determinations. For standard organization determination requests, the MA organization must provide notice of the decision no later than fourteen (14) calendar days after receipt of the request for service. If requests are expedited, the MA organization is required to notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request for an expedited organization determination. Failure to provide enrollees and/or their providers notice within the required timeframes, can result in enrollees failing to receive the approved services, or delays with accessing services and/or appeal rights.

If the organization determination is adverse (i.e., not in favor of the enrollee or provider), the enrollee or provider has the right to file an appeal. The first level of the appeal, called a reconsideration, is handled by the MA organization. The second level of appeal is made to an independent review entity (IRE) that contracts with CMS. If the MA organization does not issue the reconsideration decision timely, the decision is considered to be unfavorable to the enrollee and must be automatically sent to the IRE.

Medical coverage decisions must be made within the required timeframes and in accordance with Medicare coverage guidelines, Medicare covered benefits, each MA organization's CMS-approved coverage, and contracts with providers. This can be made by furnishing the benefits directly or through arrangements, or by paying for the benefits. If the MA organization incorrectly denies or delays coverage decisions, then enrollees may be inappropriately denied or delayed access to services, or may be held financially liable for services already received.

Additionally, if a contracted provider refers an enrollee to a non-contracted provider for a service that is covered by the MA organization upon referral, the enrollee is financially liable for only the applicable cost-sharing for that service. This is known as plan directed care and must be taken into consideration when the MA organization makes a decision to pay for services furnished by non-contracted providers. However, if the MA organization denies a request for payment from a non-contracted provider, the MA organization must provide denial notices that includes the Medicare Part C appeal rights. Those appeal rights must include a waiver of liability statement requiring the non-contracted provider to waive liability for the enrollee if the provider appeals the denied service. If the MA organization inappropriately denies plan directed care and does not provide the appropriate appeal rights to the non-contracted provider, then enrollees may incur inappropriate out-of-pocket expenses for medical services.

Violations Related to Part C Organization Determinations, Appeals and Grievances

CMS determined that BCBS of TN violated the following Part C organization determination, appeal, and grievance requirements:

1. BCBS of TN failed to notify enrollees of its decisions within the required timeframes for standard and expedited Part C organization determination requests. As a result, it is substantially likely that enrollees with approved services were impeded from obtaining medically necessary services, while others with denied services were delayed timely appeal rights. This failure violates 42 C.F.R. §§ 422.566, 422.568(b)(1), and 422.572(a).

2. BCBS of TN failed to hold enrollees harmless for Part C items or medical services provided by non-contracted providers referred by contract providers and then failed to provide those non-contracted providers with denial notices that included the applicable appeal rights and a waiver of liability statement. As a result, there is a substantial likelihood that these enrollees incurred inappropriate out-of-pocket costs for these items and services. This failure violates 42 C.F.R. §§ 422.105(a), 422.568(e), and 422.2267(e)(27).

Basis for Civil Money Penalty

Pursuant to 42 C.F.R. §§ 422.752 (c)(1)(i) and 423.752(c)(1)(i), CMS may impose a CMP for any determination made under 42 C.F.R. §§ 422.510 (a)(1) and 423.509(a)(1). Specifically, CMS may issue a CMP if a MA-PD has failed substantially to follow Medicare requirements according to its contract. Pursuant to 42 C.F.R. §§ 422.760(b)(2) and 423.760(b)(2), a penalty may be imposed for each enrollee directly adversely affected (or with the substantial likelihood of being adversely affected) by the deficiency.

CMS has determined that BCBS of TN failed substantially to carry out the terms of its contract (42 C.F.R. § 422.510(a)(1)). Additionally, CMS determined that BCBS of TN failed substantially to comply with requirements in Subpart M relating to grievances and appeals (42 C.F.R. § 422.510(a)(4)(ii)). BCBS of TN's violations of Part C requirements directly adversely affected (or had the substantial likelihood of adversely affecting) enrollees and warrants the imposition of a CMP.

Right to Request a Hearing

BCBS of TN may request a hearing to appeal CMS's determination in accordance with the procedures outlined in 42 C.F.R. Parts 422 and 423, Subpart T. BCBS of TN must send a request for a hearing to the Departmental Appeals Board (DAB) office listed below by May 23, 2022[1]. The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which BCBS of TN disagrees. BCBS of TN must also specify the basis for each contention that the finding or conclusion of law is incorrect.

[1] Pursuant to 42 C.F.R. §§ 422.1020(a)(2) and 423.1020(a)(2), the plan sponsor must file an appeal within 60 calendar days of receiving the CMP notice. The 60th day falls on a weekend or holiday, therefore the date reflected in the notice is the next regular business day for you to submit your request.

The request should be filed through the DAB E-File System (https://dab.efile.hhs.gov) unless the party is not able to file the documents electronically. If a party is unable to use DAB E-File, it must send appeal-related documents to the Civil Remedies Division using a postal or commercial delivery service at the following address:

Civil Remedies Division
Department of Health and Human Services
Departmental Appeals Board
Medicare Appeals Council, MS 6132
330 Independence Ave., S.W.
Cohen Building Room G-644
Washington, D.C. 20201

Please see https://dab.efile.hhs.gov/appeals/to_crd_instructions for additional guidance on filing the appeal.

A copy of the hearing request should also be sent to CMS at the following address:

Kevin Stansbury
Director, Division of Compliance Enforcement
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Mail Stop: C1-22-06
Email: kevin.stansbury@cms.hhs.gov

If BCBS of TN does not request an appeal in the manner and timeframe described above, the initial determination by CMS to impose a CMP will become final and due on May 24, 2022. BCBS of TN may choose to have the penalty deducted from its monthly payment, transfer the funds electronically, or mail a check to CMS. To notify CMS of your intent to make payment and for instructions on how to make payment, please call or email the enforcement contact provided in the email notification.

Impact of CMP

Further failures by BCBS of TN to provide its enrollees with Medicare benefits in accordance with CMS requirements may result in CMS imposing additional remedies available under law, including contract termination, intermediate sanctions, penalties, or other enforcement actions as described in 42 C.F.R. Parts 422 and 423, Subparts K and O.

If BCBS of TN has any questions about this notice, please call or email the enforcement contact provided in the email notification.

Sincerely,

/s/

John A. Scott
Director
Medicare Parts C and D Oversight and Enforcement Group

cc: Kevin Stansbury, CMS/CM/MOEG/DCE
Tamara McCloy, CMS/OPOLE
Mortez Williams, CMS/OPOLE
Michael Taylor, CMS/OPOLE
Sabrina Hogue, CMS/OPOLE